John Elias Baldacci
Governor

Brenda M. Harvey
Commissioner

Maine Department of Health and Human Services

REPORTABLE EVENTS

Adult Developmental Service Event:

☐ **Physical or Verbal Abuse** ☐ **Neglect** ☐ **Sexual Abuse/Exploitation** ☐ **Exploitation (Non-Sexual)**
☐ **Rights Violation** ☐ **Serious Injury to Consumer** ☐ **Suicidal Acts, Attempts, Threats** ☐ **Death**
☐ **Restraint** ☐ **Medication Error** ☐ **Dangerous Situations – Other (As listed on the following page)**

IDENTIFYING INFORMATION

Client First Name	Client Last Name	Gender M/F	Date of Birth:	Social Security Number
Event Start Date	**Event Start Time**	**Event End Date**		**Event End Time**

REPORTABLE EVENT INFORMATION

Short Description of Event:

Short Description of Actions Taken:

WORKER DETAILS

Was Worker(s) involved in event? ☐ **Yes** ☐ **No** ☐ **Unknown**
Name(s): _____
Worker Type: ☐ **Direct Service** ☐**Management/Supervisor**
Role: ☐ **Participant** ☐ **Witness**
☐ **Other (Specify)** _____

Was another Person(s) involved in event:
☐ **Yes** ☐ **No** ☐ **Unknown**
Names(s) _____
Role: ☐ **Participant** ☐ **Witness**
☐ **Other (Specify)** _____

REPORTER DETAILS

Reporter (Name, Telephone (work) #, Address, & E-mail:

Reporter Title:

Reporter ID: (Reporter's relationship to the individual who is the subject of the report)
☐ **Consumer** ☐ **Family Member** ☐ **Guardian** ☐ **Staff** ☐ **CCM** ☐ **Other (Specify)** _____

Reporter Role: ☐ **Participant in event** ☐ **Witness** ☐ **Hearsay** ☐ **Other (Specify)** _____

Method of Reporting: ☐ **Call** ☐ **E-mail** ☐ **Fax** ☐ **In-Home Visit** ☐ **Letter** ☐ **Other (Specify)** _____

Location: ☐ **Adult Day Care** ☐ **Hospital** ☐ **In Community** ☐ **Nursing Facility** ☐ **Personal Residence** ☐ **Residential Care** ☐ **Day Habilitation**
☐ **Other:** _____

SERVICE LOCATION DETAILS

Agency Name, Telephone #, & Address:

Program/Facility Name, Telephone #, Address:

AGENCY/ CONTACT / FILER DETAILS

Filer Type: ☐ **Agency Staff** ☐ **DHHS Staff** ☐ **CCM** ☐ **Guardian** ☐ **Friend** ☐ **Anonymous**
☐ **Other (Specify)** _____

Filer (Name, Telephone (work) #, & E-mail:

NOTIFICATIONS

Client's Family Notified:	☐ Yes ☐ No	Guardian Notified	☐ Yes ☐ No	☐ No Guardian
If yes, Who Notified Guardian:	**Guardian Name, Address & Phone #:**			

Client Name:_____

ADULT DEVELOPMENTAL SERVICES EVENT TYPES & CATEGORIES

The following event types must be reported IMMEDIATELY to your local DHHS Office with follow-up with written report to Regional Incident Data Specialist:

PHYSICAL OR VERBAL ABUSE

Source of Abuse
- ☐ Self
- ☐ Family Member
- ☐ Direct Care Staff
- ☐ Other Provider Staff
- ☐ Client to Client
- ☐ Other (Specify)

_____

Other Source:

_____

Type of Abuse
- ☐ Physical Abuse (Includes Assault)
- ☐ Cruel Punishment
- ☐ Unreasonable Confinement
- ☐ Emotional Abuse
- ☐ Intimidation
- ☐ Verbal Abuse

Was the person injured as a result of the abuse?
- ☐ YES ☐ NO

Was treatment required?
- ☐ YES ☐ NO

If treatment required, select location:
- ☐ Inpatient
- ☐ Outpatient
- ☐ Emergency
- ☐ Physician's Office
- ☐ Crisis Intervention

NEGLECT

Source of Neglect
- ☐ Self
- ☐ Family Member
- ☐ Direct Care Staff
- ☐ Other (Specify)

_____

Other Source:

_____

Type of Neglect
- ☐ Self Neglect
- ☐ Caregiver Neglect
- ☐ Safety Issues/At Risk
- ☐ Deprivation of essential needs
- ☐ Lack of adequate protection
- ☐ Caregiver under influence
- ☐ Inability to give informed consent

Was treatment required?
- ☐ YES ☐ NO

If treatment required, select location:
- ☐ Inpatient
- ☐ Outpatient
- ☐ Emergency Room
- ☐ Physician's Office
- ☐ Crisis Intervention

SEXUAL ABUSE/ EXPLOITATION

Source of Abuse
- ☐ Family Member
- ☐ Direct Care Staff
- ☐ Client to Client
- ☐ Other (Specify)

_____

Other: _____

Type of Alleged Abuse
- ☐ Non-consensual sexual activity
- ☐ Sexual contact by paid provider
- ☐ Client to client sexual abuse
- ☐ Sexual contact with Incompetent person

Was the person injured as a result of abuse?
- ☐ YES ☐ NO

Was treatment required?
- ☐ YES ☐ NO

Treatment Location:
- ☐ Inpatient
- ☐ Outpatient
- ☐ Emergency Room
- ☐ Physician's Office
- ☐ Sexual Abuse Assault Line
- ☐ Other Crisis Helpline:

_____

_____

EXPLOITATION (NONSEXUAL)

Exploitation Source
- ☐ Family Member
- ☐ Provider Direct Care Staff
- ☐ Provider Non-Direct Service Staff
- ☐ Client to Client
- ☐ Other (Specify)

Other:

_____

Other Suspect Perpetrator Type (Do Not Use Name)

_____

_____

Exploitation Type
- ☐ Unpaid/Inadequately Paid Work
- ☐ Financial Theft/Exploitation
- ☐ Property Theft
- ☐ Property Damage
- ☐ Medication Theft
- ☐ Other (Specify)

Other:

_____

Other Exploitation Type

_____

_____

_____

_____

RIGHTS VIOLATIONS

- ☐ Behavior Modifications
- ☐ Communications
- ☐ Discipline
- ☐ Humane treatment
- ☐ Medical Care
- ☐ Nutrition
- ☐ Personal property
- ☐ Physical Exercise
- ☐ Physical Restraints
- ☐ Religions Practice
- ☐ Records
- ☐ Social Activity
- ☐ Sterilization
- ☐ Voting
- ☐ Work

SERIOUS INJURY TO CONSUMER

Serious Injury Type
- ☐ Laceration requiring sutures or staples
- ☐ Bone Fracture
- ☐ Joint Dislocation
- ☐ Loss of Limb
- ☐ Serious Burn
- ☐ Skin wound due to poor care
- ☐ Other (Specify)

_____

Other Injury Type:

_____

Cause of Injury
- ☐ Fall
- ☐ Accident
- ☐ Seizure
- ☐ Medical Condition
- ☐ Treatment Error
- ☐ Poor Care
- ☐ Origin Unknown
- ☐ Other (Specify)

_____

Where did person receive treatment:
- ☐ Inpatient
- ☐ Outpatient
- ☐ Emergency Room
- ☐ Physician's Office
- ☐ Emergency Intervention On-Site
- ☐ Other (Specify):

_____

Other Injury Treatment Location:

_____

DANGEROUS SITUATIONS – OTHER

Other Event Types
- ☐ Criminal justice Involvement
- ☐ Consumer Violence (Non-Assault)
- ☐ Runaway
- ☐ Lost/Missing Person
- ☐ Loss of Home (Disaster)
- ☐ Arson
- ☐ Hostage Taking
- ☐ Other Event Jeopardy to Client and/or Public Safety

Specify Other Significant Jeopardy Event Type:

_____

_____

Why is this event of particular risk to this person?

_____

_____

Was Emergency Services involved?
- ☐ Ambulance Rescue/Paramedics
- ☐ Law Enforcement
- ☐ Fire Department
- ☐ Warden Services
- ☐ Crisis Outreach Team
- ☐ Other Emergency Service

SUICIDAL ACTS, ATTEMPTS, THREATS

Suicidal Act/Attempt/Threat
- ☐ Serious attempts
- ☐ Threats

Was treatment provided as a result of attempt?
- ☐ YES
- ☐ NO

Treatment Location:
- ☐ Inpatient
- ☐ Outpatient
- ☐ Emergency Room
- ☐ Physician's Office
- ☐ Crisis Intervention
- ☐ Other (Specify):

_____

Other Treatment Location:

_____

DEATH

- ☐ Completed suicide
- ☐ Homicide
- ☐ Natural Causes Age Related
- ☐ Accidental Death
- ☐ Complication to Illness
- ☐ Unexplained death
- ☐ Other Death (Specify)

_____

_____

The only approved behavioral methods for use in emergencies are <u>Personal holding/Restraint or Chemical Restraint</u>. The permitted use of emergency personal holding is to protect the person from physically injuring himself/herself or some other nearby person. Chemical restraint must be performed under medical order and supervision. Emergency chemical restraint orders must be renewed every 12 hours. Each drug administration must e reported. <u>All other forms of severely intrusive behavior management are strictly forbidden for use on an emergency basis including the use of locked time out or any other aversive procedure.</u>

Client Name: _____

RESTRAINT(S)

Is this an Incidental Restraint to the Reportable Event? ☐ **Yes** ☐ **No**

Behavioral Method (Mark Type of Restraint)

- ☐ Personal Holding Restraint
- ☐ Blocking
- ☐ Chemical restraint

Drug Used: _____

Single Restraint ☐ **Yes** ☐ **No**

Time Start: _____

Time End: _____ Time Total: _____

Multiple Restraint ☐ **Yes** ☐ **No**

Start 1st Restr.: _____ End Last Restr.: _____

Total Time of Restraints Only (not the incident time): _____

Number of Restraints _____

Precipitating Conditions and Behavior Changes

- ☐ Unknown – no observed circumstances.
- ☐ Gradual increase in agitation due to Behavior.
- ☐ Explosive aggression with environment stress.
- ☐ Explosive aggression without provocation.
- ☐ Other Precipitation _____

Behavior Exhibited

- ☐ Assault on staff. _____
- ☐ Assault on others. _____
- ☐ Self-injury _____
- ☐ Other Behavior: _____

Intervention Steps

- ☐ Asked individual to stop the behavior.
- ☐ Encouraged the individual to express concern or difficulty.
- ☐ Attempted alternate activity – distraction
- ☐ Offered other choices.
- ☐ Changed the environment to reduce stress.
- ☐ Mediated the conflict between the person and other(s).
- ☐ Other Intervention: _____

General Information

- ☐ Medical attention required – Report to DHHS.
- ☐ Medical attention to other person.
- ☐ Medical attention to staff.
- ☐ Damage to personal property.
- ☐ Damage to staff property.
- ☐ Damage to others property.
- ☐ Minor staff injury – no outside treatment.
- ☐ Minor injury to self – no outside medical treatment required.
- ☐ No injury.
- ☐ No property damage.

Procedure Effectiveness

- ☐ High – Person calmed down – No further incident.
- ☐ Moderate – Continued minor disruption – No intervention needed.
- ☐ Low – Individual required continued attention.
- ☐ None – Second use of intervention.

MEDICATION ERROR

Medication Event Type

- ☐ Omission
- ☐ Wrong Dose
- ☐ Wrong Medication
- ☐ Wrong Method of Administration
- ☐ Wrong Route
- ☐ Wrong Time (> 1 Hr. Variance)
- ☐ Medication Refused
- ☐ Non-Compliance
- ☐ Other (Specify) _____

Medication Event Other: _____

Event Reason

- ☐ Administration Error
- ☐ Supply Exhausted
- ☐ Forgot
- ☐ Refusal
- ☐ Prescription Unfilled
- ☐ Incorrect Chart Entry
- ☐ Non-Compliance
- ☐ Other Reason (Specify) _____
- ☐ Forgot to take on Activity
- ☐ Forgot to send to program

Other Reason for Event: _____

Administered/Set-Up By

- ☐ Consumer
- ☐ Provider
- ☐ Provider Set-up Only
- ☐ Provider Admin. Only
- ☐ Family Member
- ☐ Direct Service Worker
- ☐ Other (Specify) _____

Administered by Other: _____

Name of Drug: _____

Was Treatment Required as a Result of Problem?

☐ **Yes** ☐ **No**

Treatment Type

- ☐ Inpatient
- ☐ Outpatient
- ☐ Emergency Room
- ☐ Physician's Office
- ☐ Emergency Intervention On-Site

Was the Nurse/Physician/ER Contacted?

- ☐ Nurse
- ☐ Physician
- ☐ Emergency Room

Date of Contact: _____ Time of Contact: _____

What instructions were given? _____